



**MONICA J. LINDEEN**  
COMMISSIONER OF SECURITIES & INSURANCE  
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## INSURANCE INQUIRY/COMPLAINT FORM

In response to your recent request for assistance, we are sending our Insurance Inquiry/Complaint Report Form. Please complete this form and mail to the above captioned address to the attention of PHS (Policy Holder Services). It often takes several weeks for the Department to complete the review and take appropriate action. You will hear from a Compliance Specialist, in writing, as soon as the review is complete.

Your Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
(Mailing Address) (City) (State) (Zip Code)

Insurance Company's Name \_\_\_\_\_

Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_

Kind of Policy: ☐ Auto ☐ Life ☐ Health ☐ Property ☐ Other \_\_\_\_\_

Agent's Name \_\_\_\_\_ Date of Loss: \_\_\_\_\_

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*Please indicate which of the following is applicable:*

My complaint is against: ☐ COMPANY ☐ AGENT ☐ ADJUSTER

1. ☐ The company has unfairly rejected my claim or has not paid the full benefits to which I am entitled.
2. ☐ The company has delayed processing my claim and I am unable to obtain a response from them concerning it.
3. ☐ The company has not refunded premium moneys that are due to me.
4. ☐ I believe the company's action of cancellation or non-renewal of my policy is not justified.
5. ☐ Other \_\_\_\_\_

Do you have an attorney handling this for you? ☐ If not, in your own words, describe your problem. If more space is needed, please add additional sheets. Enclose copies of papers and other correspondence relative to this problem. A copy of this form may be forwarded to the insurance company involved. By signing this form, I hereby give the Office of the State Auditor permission to investigate this complaint on my behalf and forward it to the insurance company/agent for a formal response.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Use reverse for additional comments*